Complete Summary

GUIDELINE TITLE

Primary care approach to the HIV-infected patient.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Primary care approach to the HIV-infected patient. New York (NY): New York State Department of Health; 2004. 18 p. [9 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Human immunodeficiency virus (HIV) infection

GUIDELINE CATEGORY

Counseling
Evaluation
Management
Prevention
Screening

CLINICAL SPECIALTY

Allergy and Immunology
Family Practice

Infectious Diseases
Internal Medicine
Nursing
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To develop guidelines for evaluation and management of human immunodeficiency virus (HIV)-infected patients in primary care

TARGET POPULATION

Human immunodeficiency virus (HIV)-infected patients in primary care

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation/Assessment

1. General medical history including
    - History of present illness
    - Past hospitalizations
    - Past immunizations
    - Occupational history
    - Allergies
    - Mental health
2. Human immunodeficiency virus (HIV)-related history including
    - HIV treatment history and staging
    - History of HIV-related illness and opportunistic infections
    - History of sexually transmitted diseases
    - History of tuberculosis
    - Psychiatric history
    - Transfusion/blood product history
    - Review of past medical care
    - Review of systems
    - Sexual history
    - Substance use history
3. Comprehensive physical examination including
    - Vital signs and pain assessment
    - Ophthalmologic assessment and referral
    - Oral examination
    - Ears, nose, and throat examination
    - Dermatologic examination

- Lymph node examination
- Pulmonary and cardiac examination
- Abdominal examination
- Genital examination
- Rectal examination
- Neurologic examination

4. Laboratory assessment and diagnostic testing including
    - Immunologic assessment
    - Virologic assessment
    - Tuberculosis evaluation
    - Syphilis evaluation
    - Cervical Pap smears

Management/Counseling

1. Behavioral health counseling including
    - Safer sex education
    - Substance use assessment and counseling
    - Smoking cessation education
    - Reproductive counseling
    - Domestic violence screening
    - Psychological assessment
2. Initiation of antiretroviral therapy emphasizing adherence to therapy and monitoring potential side effects and tolerability
3. Coordination of care using case management
4. Appropriate use of acute and chronic care services

Prevention

1. Opportunistic infection prophylaxis (trimethoprim/sulfamethoxazole, azithromycin, clarithromycin)
2. Immunizations including pneumococcal vaccine, influenza vaccine, hepatitis A and B vaccine
3. Standard health maintenance interventions, such as mammogram, colonoscopy, occult blood, prostate specific antigen (PSA)

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Human Immunodeficiency Virus (HIV) Guidelines Program works directly with committees composed of HIV Specialists to develop clinical practice guidelines. These specialists represent different disciplines associated with HIV care, including infectious diseases, family medicine, obstetrics and gynecology, among others. Generally, committees meet in person 3 to 4 times per year, and otherwise conduct business through monthly conference calls.

Committees meet to determine priorities of content, review literature, and weigh evidence for a given topic. These discussions are followed by careful deliberation to craft recommendations that can guide HIV primary care practitioners in the delivery of HIV care. Decision making occurs by consensus. When sufficient evidence is unavailable to support a specific recommendation that addresses an important component of HIV care, the group relies on their collective best practice experience to develop the final statement. The text is then drafted by one member, reviewed and modified by the committee, edited by medical writers, and then submitted for peer review.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The guideline developers reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Both human immunodeficiency virus (HIV) Specialists and general practitioners should be capable of evaluating HIV-infected patients during all stages of the disease.

HIV-infected patients who are clinically stable, whether receiving antiretroviral (ARV) therapy or not, should have follow-up visits at least every 3 to 4 months. Visits may be scheduled more frequently at entry to care, when starting or changing ARV regimens, or for management of acute problems.

Baseline History

The clinician should obtain a general medical history (see Table below titled, "Elements of General History for HIV-Infected Patients") as well as an HIV-specific history (see Table below titled "Elements of an HIV-Related History") and should perform a full review of systems.

When obtaining the patient's history, the clinician should use vocabulary that the patient can understand regardless of education level.

General Medical History

Clinicians should obtain a general medical history for HIV-infected patients during the initial evaluation

Elements of General History for HIV-Infected Patients
• History of present illness • Past hospitalizations and past and current illnesses • Past immunizations • Travel history/place of birth • Occupational history and hobbies • Pets/animal exposures • Current prescription and non-prescription medicines* • Allergies • Full review of systems • Mental health

* Includes use of complementary and alternative medicine, illicit substances, and use of hormones

HIV-related History

Clinicians should obtain a comprehensive HIV-related history, including a psychosocial history, during the initial evaluation.

Elements of HIV-Related History
HIV treatment history and staging • Most recent viral load and CD4 count • Nadir CD4 and peak viral load • Current and previous ARV regimens • Previous adverse ARV drug reactions • Previous adverse reactions to drugs used for opportunistic infection (OI) prophylaxis History of HIV-related illness and opportunistic infections (e.g., shingles, diarrhea, seborrheic dermatitis, thrush, Centers for Disease Control and Prevention [CDC] acquired immune deficiency syndrome [AIDS]-defining illnesses) History of sexually transmitted diseases (e.g., syphilis, herpes simplex, venereal warts, chlamydia, gonorrhea) History of tuberculosis (e.g., treatment, purified protein derivative [PPD] status, last test) History of hepatitis and hepatitis vaccines, if known Psychiatric history • Diagnosed psychiatric disease(s) • Previous/current treatment(s) of psychiatric disease(s) • Disability related to psychiatric disease • Homicidality/suicidality Transfusion or blood product history, especially before 1985 Review of sources of past medical care (obtain medical records whenever possible) HIV-specific review of systems • Skin: rash, pruritus, skin diseases, such as psoriasis, folliculitis, molluscum contagiosum • Eyes: change in vision, including blurry vision, double vision, flashes of light, or loss of vision • Ears, nose, throat: sinus infections, dysphagia, odynophagia, dental pain, hearing loss

Elements of HIV-Related History

• Pulmonary: cough, dyspnea at rest or on exertion, hemoptysis
• Cardiac: chest pain, palpitations, heart murmur
• Abdominal: nausea, vomiting, diarrhea, constipation, blood per rectum, hemorrhoids
• Genitourinary: vaginal or penile discharge, vaginal pain, dysuria, genital/rectal warts or ulcers
• OB/GYN: vaginal discharge, bleeding, pain, infections; last Pap and result; pregnancies, births, termination of pregnancy; current contraceptive use and needs
• Extremities: muscle weakness, muscle wasting, muscle pain, joint swelling
• Neurologic: tingling, burning, pain, or numbness in the extremities, weakness
 	
Sexual history
 	
• Sexual practices (e.g., vaginal, anal, oral)
• Gender identity
• Past and current partners
• Risk behavior assessment (e.g., use of latex barriers, number of partners)
 	
Substance use history
 	
• Types of drugs (past and current use)
  • Street drugs (e.g., marijuana, cocaine, heroin, methamphetamine, MDMA/ecstasy)
  • Prescription drugs (illicit use)
  • Alcohol
• Frequency of use and usual route of administration
• Risk behavior assessment (e.g., drug/needle sharing, exchanging sex for drugs, sexual risk-taking while under the influence of drugs or alcohol)
• History of treatment
 	
Tobacco use history

The clinician should document in the medical record that the patient is infected with

HIV based on an HIV enzyme-linked immunosorbent assay (ELISA) antibody test or rapid test that is confirmed by serum Western blot.

Previous medical records from past providers of medical care should be obtained.

When obtaining non-prescription drug use and sexual histories, clinicians should establish a supportive environment that facilitates the discussion of sensitive issues and is conducive to the building of trust.

At every visit, the clinician should assess the patient for new symptoms and HIV-related complications.

If new symptoms or complications indicate initiating, changing, or terminating ARV therapy, the clinician should consult with an HIV Specialist.

Comprehensive Physical Examination

Clinicians should perform a baseline and annual comprehensive physical examination, paying particular attention to areas potentially affected by HIV.

Elements of a Comprehensive Physical Examination for HIV-Infected Patients*
Vital signs (assess at each visit) Pain assessment (assess at each visit) Ophthalmologic examination Funduscopic examination Ears, nose, and throat examination Examine for the following: • sinus infection • odynophagia • dysphagia • hearing loss Dermatologic examination Examine for all skin conditions, including the following: • seborrheic dermatitis • psoriasis • maceration of the gluteal cleft • Kaposi's sarcoma • molluscum contagiosum • onychomycosis • diffuse folliculitis with pruritus Lymph node examination Examine for the following: • supraclavicular and axillary nodes • clusters of large nodes • asymmetric nodes • sudden increase in size or firmness of nodes Oral examination

Elements of a Comprehensive Physical Examination for HIV-Infected Patients*

Examine for the following:

- oral candidiasis (thrush)
- hairy leukoplakia (examine lateral borders of tongue)
- Kaposi's sarcoma
- gingival disease
- aphthous ulcers
- periodontal disease
- oral herpes simplex

Pulmonary examination

Examine for the following:

- lung fields for wheezes, rhonchi, rales, or dullness

Cardiac examination

Examine for the following:

- heart rhythm
- heart murmur, click, or rub

Abdominal examination

Examine for the following:

- hepatosplenomegaly
- multiple lipomata in the subcutaneous fat
- increased visceral fat

Genital examination

- Examine for the following in both men and women:
    - venereal warts (human papillomavirus [HPV])
    - classic and atypical herpes simplex virus (HSV)
    - ulcerative genital disease
- Perform a careful pelvic examination in women
- For adolescents, assess sexual maturity according to Tanner scale

Rectal examination

Examine for visible anal lesions or evidence of skin abnormality around the anus

- Consider obtaining an anal Pap smear in men and women with visible anal lesions or evidence of skin abnormality around the anus
- Perform digital rectal exam

Elements of a Comprehensive Physical Examination for HIV-Infected Patients*
Neurologic examination • Mental status examination • Examination of cranial nerves • Examine for sensory and motor abnormalities, cerebellar function • Screen for depression and anxiety • Assess appetite and sleep habits

*Except where indicated, each element should be performed at least annually.

Vital Signs and Pain Assessment

Clinicians should assess weight at each visit.

Clinicians should ask HIV-infected patients about pain at each visit. They should document any complaints of pain and respond with efforts to alleviate it.

Clinicians should not deny treatment of pain because of a history of addiction.

Clinicians should consider referring patients with chronic pain to a pain management specialist.

Ophthalmologic Assessment and Referral

Patients with CD4 counts <50 cells/mm3 should be examined by an ophthalmologist at baseline and every 6 months.

Patients with visual disturbances or unremitting ocular symptoms, regardless of CD4 cell count, should be evaluated by an ophthalmologist.

Oral Examination

Clinicians should ascertain whether their patients have a regular oral health provider and should refer all HIV-infected patients for annual oral examinations and hygiene.

Genital Examination

Clinicians should examine for venereal warts (human papilloma virus [HPV]) and evidence of classic herpes simplex virus (HSV) infection or atypical HSV (e.g., non-healing gluteal cleft maceration).

Rectal Examination

A digital rectal examination should be performed in both male and female patients.

Anal Pap smears in men who have sex with men are not routinely recommended.

Neurologic Examination

A mental health assessment should be performed at baseline and annually and should include the following components:

- Cognitive function assessment, including mental status
- Depression and anxiety screening
- Psychiatric history
- Psychiatric medications review
- Sleep habits and appetite assessment

Clinicians should refer patients to appropriate mental health providers and/or agencies when indicated.

Laboratory Assessment and Diagnostic Testing

Clinicians should order appropriate laboratory assessments and screening tests for management of HIV-infected patients.

Routine Laboratory Assessment And Diagnostic Screening
Immunologic assessment (baseline and every 3 to 4 months) CD4 lymphocyte count and percentage; to produce reliable results, the same testing laboratory should be used Virologic assessment • Quantitative HIV ribonucleic acid (RNA) testing for viral load assessment (baseline and at least every 3 months); the same testing method should be used • Genotypic resistance testing should be performed 1) prior to initiating treatment in ARV therapy-naïve patients to determine whether they were infected with drug-resistant virus, and 2) in patients experiencing virologic failure or incomplete viral suppression while receiving ARV therapy Tuberculosis (TB) evaluation (baseline and annually) • PPD skin test for patients with no previous history of TB or no previous positive PPD • Chest x-ray for patients known to have a history of TB or known to be PPD positive Screening for sexually transmitted diseases (STDs)* • Rapid plasma reagin (RPR) or Venereal Disease Research Laboratory (VDRL) for syphilis with verification of positive test by confirmatory Fluorescent Treponemal Antibody Absorption Test (FTA-Abs) or microhemagglutination-treponema pallidum (MHA-TP) (baseline and at least annually)

Routine Laboratory Assessment And Diagnostic Screening

• For females:
  • Culture or deoxyribonucleic acid (DNA) amplification test for gonorrhea (baseline and at least annually)
  • Immunofluorescence, or DNA amplification test for chlamydia (baseline and at least annually)
 	
Pap smears for HIV-infected women
 	
• Obtain at baseline and then 6 months after baseline. Repeat annually, as long as results are normal.
• Abnormal Pap smears should be repeated every 3 to 6 months until there have been two successive normal Pap smears**
 	
Complete blood count, including differential (baseline and every 3 months)
 	
Serum creatinine, blood urea nitrogen (BUN), total protein, albumin (baseline and every 3 months)
 	
Serum liver enzymes, amylase, lipase, cholesterol levels, triglycerides, serum CPK (every 3 months for patients receiving ARV therapy)
 	
Urinalysis (baseline and at least annually)
 	
Additional baseline tests
 	
• Hepatitis A antibody screening for the following populations who have not been previously vaccinated: men who have sex with men, injection drug users, those from an endemic area, and those with liver disease
• Hepatitis B serology
• Hepatitis C serology***
• Toxoplasma gondii antibody screening
• Varicella antibody screening for adults without a history of chickenpox

* Patients who continue to engage in unsafe sexual practices are at increased risk for other STDs. Patients with any other STDs, whether ulcerative or not, are at higher risk for HIV transmission. Recent increases in STDs among men who have sex with men (MSM) warrant screening of asymptomatic sexually active patients (see Chapter 6: Atypical Presentations of STDs).

** Follow-up for abnormal Pap smears varies on a case-by-case basis.

*** A qualitative HCV RNA polymerase chain reaction (PCR) should be obtained when no hepatitis antibodies are detectable in a patient with elevated serum liver enzymes and risk factors for HCV.

Immunologic Assessment

The CD4 lymphocyte profile should include both the absolute count and percentage.

Virologic Assessment

The initial test performed to measure HIV viral load in an ARV therapy-naïve individual should be a standard viral load assay, not an ultrasensitive test.

Viral load should be obtained before vaccinations and not during intercurrent illness because these situations may lead to a transient elevation in viral load.

Clinicians should seek expert consultation for interpretation of genotypes.

Tuberculosis Evaluation

Clinicians should obtain a PPD skin test unless the patient has previously tested positive or has had previously documented TB.

Clinicians should prescribe TB prophylaxis when a PPD skin test results in induration of ≥5 mm.

Behavioral Health Counseling

Clinicians should provide routine behavioral health counseling for HIV-infected patients (see Table 5 in the original guideline document).

Safer Sex Education

Clinicians should discuss safer sexual practices with HIV-infected patients on a routine and ongoing basis.

Clinicians should routinely discuss with patients the importance of partner notification. Patients should be educated about the options for voluntary partner notification. These discussions should be clearly documented. The New York State HIV Reporting and Partner Notification Law is available at www.hivguidelines.org

Clinicians should emphasize that transmission of HIV may occur during unprotected sex even when patients have undetectable HIV plasma viral loads.

Clinicians should recommend the use of latex condoms and should discuss the option of using polyurethane female condoms.

Clinicians should instruct patients in the proper use of condoms, dental dams, and other barriers to reduce HIV transmission.

Clinicians should educate their patients to avoid using condoms and creams containing nonoxynol-9.

Substance Use Assessment and Counseling

Clinicians should assess substance use at each routine visit and, when necessary, refer patients for inpatient or outpatient rehabilitation.

When current addiction issues are identified, clinicians should discuss the possible effects of such use on one's general health and HIV medications, as well as

options for rehabilitation. These discussions should be properly documented in the patient's chart.

Clinicians should evaluate for possible interactions among illicit drugs and prescription drugs.

Clinicians should counsel HIV-infected drug users who continue to inject drugs to use their own needle, syringe, filtration cotton, and cooker, and not to share with others. These individuals should also be informed about sources where they can obtain sterile injection equipment, such as syringe exchange programs and pharmacies participating in the Expanded Syringe Access Demonstration Program (ESAP). Some physicians may prescribe syringes to patients who inject drugs.

For appropriate follow-up of addiction issues, clinicians should utilize social work and/or mental health services, in conjunction with substance use counselors (when available).

Tobacco Use Assessment and Counseling

Clinicians should assess smoking status and should encourage those who smoke to stop. Referrals to smoking cessation programs should be provided if the patient is interested.

Domestic Violence

Clinicians should annually screen all male and female HIV-infected patients for current and lifetime domestic violence.

When real or potential domestic violence is recognized, social work services should be involved, and referrals should be made to domestic violence organizations or domestic violence counseling. In the absence of social work services, clinicians should be familiar with resources available in the community and mechanisms of referral.

Psychosocial Assessment

The clinician or a member of the health care team should perform at least annual psychosocial assessments of HIV-infected patients (refer to Table 5 in the original guideline document).

The clinician should work with the patient's case manager (if the patient receives case management) to provide necessary medical guidance related to active psychosocial issue(s).

Use of Antiretroviral Therapy and Related Assessments

Starting Antiretroviral Therapy

Patients should be involved in planning the treatment regimen and should agree to it before therapy is initiated.

The decision to begin ARV therapy should be individualized, made in the context of careful patient counseling and education, and based on an assessment of four major factors:

- The patient's risk of progression to illness or death if left untreated
- The patient's willingness and ability to adhere to the therapy prescribed
- The presence of adherence obstacles
- The risk of long-term toxicity

Provided that the patient is willing to adhere to the prescribed ARV regimen and that barriers to adherence are minimized, treatment is generally recommended for patients meeting any one of the following four criteria:

- CDC-defined AIDS
- HIV-related signs or symptoms
- CD4 count <350 cells/mm^3
- HIV viral load (reverse transcription (RT)-PCR or bDNA) >55,000 copies/mL

Adherence to Antiretroviral Medication

Treatment adherence should be assessed quantitatively at every visit. Questions regarding adherence should be presented to the patient in a non-threatening and non-judgmental manner in order to obtain an honest answer.

Tolerability of Medications/Side Effects

The clinician should perform a detailed review concerning the tolerability and potential side effects of ARV medications.

Preventive Medicine

Opportunistic Infection (OI) Prophylaxis

Prophylaxis should be initiated for specific opportunistic infections as indicated in Table 7 of the original guideline document and discontinued as indicated in Table 8 of the original guideline document.

Immunizations

Live vaccines in HIV-infected patients (with the exception of measles, mumps, rubella [MMR]) are contraindicated.

Pneumococcal vaccine should be administered every 5 to 6 years in HIV-infected patients.

Influenza vaccine should be administered yearly in HIV-infected patients.

Clinicians should offer hepatitis A vaccine to the following patients:

- Persons with chronic liver disease (e.g., hepatitis B or C)

- Men who have sex with men
- Travelers to countries with high endemicity of infection
- Persons who live in a community experiencing an outbreak of hepatitis A virus (HAV) infection
- Illicit drug users, particularly injection drug users
- Persons who have clotting-factor disorders

Clinicians should strongly encourage all HIV-infected patients without serologic evidence of prior hepatitis B virus (HBV) infection or history of prior HBV vaccination (complete series) to receive the hepatitis B vaccination series.

Patients who are at increased risk for both hepatitis A and hepatitis B infection and not immune to these viruses may be given the combined hepatitis A and B vaccine in a total of three doses at 0, 1, and 6 months.

Standard Health Maintenance

Clinicians should discuss general preventive health care and health maintenance with all HIV-infected patients routinely and at a minimum annually.

Standardized age- and sex-appropriate health maintenance interventions, such as cancer screening, should be performed in HIV-infected patients according to the same guidelines used for non-HIV-infected patients (see Table 9 in the original guideline document).

Patients should be instructed on how to perform breast and testicular self-examinations.

Coordination of Care

As part of the initial visit, the clinician should educate new patients on the following items:

- How to access emergency services (provide a phone number for 24-hour services)
- Whom to contact to schedule appointments
- How to obtain laboratory and radiology results, medical records, and other reports

After receiving patient consent, clinicians should share information with other agencies from which their patients are receiving services.

Case management should be used to enhance coordination of care provided by various agencies (e.g., home care, nutrition services, nursing services, and others) and to prevent duplication of services.

Clinicians should regularly involve case managers in case conferences to discuss psychosocial issues that may affect a patient's ability to adhere to care.

Appropriate Use of Acute Care Services

Outpatient clinicians who do not provide inpatient care should have a network of practitioners with whom they can communicate easily should their patients require hospitalization. Similarly, inpatient clinicians should ensure that the details of hospitalization, including the discharge medications and plans, are sent in a timely fashion to the outpatient clinicians.

Appropriate Use of Chronic Care Services

Home Health Care

Home health nurses should have a copy of the patient's medication list, active problem list, and any other information that will assist them in providing good care.

Hospice

As HIV disease progresses, clinicians should discuss patients' feelings about end-of-life care before they are unable to make decisions. All patients should be encouraged to have a living will and a health care proxy. Any medical decisions that are made should be in conjunction with the patient, or, if the patient is unable to decide for neurological reasons, with the patient's health care proxy.

Clinicians should be familiar with hospice services available in their area and should make referrals to them early enough for the patient to get full benefit of their support.

Clinicians should work in conjunction with hospice staff to establish which medical interventions may still be appropriate as quality of life declines.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate evaluation and management of human immunodeficiency virus (HIV)-infected patients in primary care

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Following the development and dissemination of guidelines, the next crucial steps are adoption and implementation. Once practitioners become familiar with the content of guidelines, they can then consider how to change the ways in which they take care of their patients. This may involve changing systems that are part of the office or clinic in which they practice. Changes may be implemented rapidly, especially when clear outcomes have been demonstrated to result from the new practice such as prescribing new medication regimens. In other cases, such as diagnostic screening or oral health delivery, however, barriers emerge which prevent effective implementation. Strategies to promote implementation, such as through quality of care monitoring or dissemination of best practices, are listed and illustrated in the companion document to the original guideline (HIV clinical practice guidelines, New York State Department of Health; 2003), which portrays New York's HIV Guidelines Program. The general implementation strategy is outlined below.

- Statement of purpose and goal to encourage adoption and implementation of guidelines into clinical practice by target audience
- Define target audience (providers, consumers, support service providers).
    - Are there groups within this audience that need to be identified and approached with different strategies (e.g., HIV Specialists, family practitioners, minority providers, professional groups, rural-based providers)?
- Define implementation methods.
    - What are the best methods to reach these specific groups (e.g., performance measurement consumer materials, media, conferences)?
- Determine appropriate implementation processes.
    - What steps need to be taken to make these activities happen?
    - What necessary processes are internal to the organization (e.g., coordination with colleagues, monitoring of activities)?
    - What necessary processes are external to the organization (e.g., meetings with external groups, conferences)?
    - Are there opinion leaders that can be identified from the target audience that can champion the topic and influence opinion?
- Monitor progress.
    - What is the flow of activities associated with the implementation process and which can be tracked to monitor the process?
- Evaluate.
    - Did the processes and strategies work? Were the guidelines implemented?
    - What could be improved in future endeavors?

IMPLEMENTATION TOOLS

Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care
Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Primary care approach to the HIV-infected patient. New York (NY): New York State Department of Health; 2004. 18 p. [9 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

GUIDELINE COMMITTEE

Medical Care Criteria Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Chair: Amneris Luque, MD, Associate Professor of Medicine, University of Rochester Medical Center, Rochester, NY, Medical Director, AIDS Center, Strong Memorial Hospital

Committee Vice-Chair: Sheldon Brown, MD, Liaison, Department of Veterans Affairs Medical Center, Associate Professor of Medicine, Mount Sinai School of Medicine, New York, NY, Chief, Infectious Disease Section, Bronx Veteran Affairs Medical Center (111F)

Committee Members: Bruce Agins, MD, MPH, Assistant Professor of Medicine, Cornell University Medical College, New York, NY, Medical Director, AIDS Institute, New York State Department of Health; Doug Fish, MD, Head, Division of HIV Medicine, Assistant Professor of Medicine, Albany Medical College; Charles Gonzalez, MD, Assistant Professor of Medicine, New York University School of Medicine, New York, NY, Clinical Investigator, AIDS Clinical Trials Unit, New York University Medical Center - Bellevue Hospital Center; Harold Horowitz, MD, Professor of Medicine, New York Medical College, Valhalla, NY 10595-1696, Medical Director, AIDS Care Center, Division of Infectious Diseases, Westchester Medical Center; Marc Johnson, MD, Attending Physician, New York Hospital Queens, Flushing, NY, Assistant Professor of Medicine, Mount Sinai School of Medicine, New York, NY, Medical Director, New York Hospital Queens Primary Care at ACQC; Jessica Justman, MD, Associate Professor of Clinical Medicine, Albert Einstein College of Medicine, Bronx, New York, Associate Director, Center for Infectious Disease Epidemiologic Research, Mailman School of Public Health, Columbia University; Sharon Mannheimer, MD, Assistant Professor of Clinical Medicine, Columbia University College of Physicians and Surgeons, New York, New York, Division of Infectious Diseases, Harlem Hospital Center; Neal Rzepkowski, MD, HIV Care Consultant, New York State Department of Corrections, WENDE HUB, HIV Care Provider, Erie County Medical Center Rural Outreach Clinics, Chautouquez County Department of Health HIV Clinics; Kent Sepkowitz, MD, Memorial Sloan-Kettering Cancer Center; Rona Vail, MD, HIV Clinical Director, Callen-Lorde Community Health Center; Barry Zingman, MD, Medical Director, AIDS Center, Montefiore Medical Center

Liaisons: Barbara Chaffee, MD, MPH; Joseph R. Masci, MD; Noemi Nagy

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Primary care approach to the HIV-infected patient. Tables and recommendations. New York (NY): New York State Department of Health; 2004 Mar. 13 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- HIV clinical practice guidelines. New York (NY): New York State Department of Health; 2003. 36 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- HIV specialist policy. New York (NY): New York State Department of Health; 2003 Mar. Electronic copies: Available in Portable Document Format (PDF) from the New York State Department of Health AIDS Institute Web site.

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

PATIENT RESOURCES

None available

NGC STATUS

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Date Modified: 9/25/2006